HOUSE BILL No. 1643

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8.1; IC 27-8; IC 27-13-36.2.

Synopsis: Health insurance claim filing and payment. Specifies certain requirements for provider submission and payment of claims under state employee health benefit plans, accident and sickness insurance policies, and health maintenance organization contracts. Repeals the law requiring use of certain billing codes for health maintenance organization claims filing and payment.

Effective: July 1, 2005.

Ripley

January 19, 2005, read first time and referred to Committee on Insurance.

Introduced

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

HOUSE BILL No. 1643

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8.1-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. **(a)** As used in this chapter, "clean claim" means a claim submitted by a provider for payment under a health benefit plan that has no defect **or** impropriety, **including a lack of supporting documentation,** or particular circumstance requiring special treatment preventing payment.

(b) The term does not include a:

(1) duplicate claim; or

(2) claim that:

(A) is submitted more than forty (40) days after the date of service; or

(B) does not comply with the electronic transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 2. IC 5-10-8.1-3.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2005]: **Sec. 3.3. As used in this chapter, "duplicate claim" means a duplicate of an original claim when the duplicate is filed less than thirty (30) days after the filing of the original claim.**

SECTION 3. IC 5-10-8.1-5.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 5.5. As used in this chapter, "supporting documentation" includes:**

(1) verification of employer and covered individual coverage under a health benefit plan;

(2) confirmation of premium payment;

(3) medical information concerning the covered individual and health care services provided;

(4) information concerning:

(A) the responsibility of another third party payor to make payment; or

(B) confirmation of the amount paid by another third party payor; or

(5) information related to a diagnosis, a treatment, or the provider's identification.

SECTION 4. IC 5-10-8.1-5.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 5.6. (a) An administrator and a provider shall, in connection with all claims, use the medical data code sets adopted by the United States Secretary of Health and Human Services under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).**

(b) An administrator shall comply with the federal regulations promulgated under Sections 503 and 505 of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) in paying a claim submitted by a provider for payment under a health benefit plan.

(c) An administrator is not required to pay, and this chapter does not apply to, a claim that is not filed in compliance with the requirements for electronic transaction standards and code sets that govern the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 5. IC 5-10-8.1-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 5.7. (a) A provider shall submit a claim for payment under a health benefit plan to the**

administrator:

(1) not more than forty-five (45) days after the date the claim was incurred, or according to the contractual terms agreed to between the administrator and provider; and

(2) according to the requirements for the electronic transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

(b) If an administrator requires supporting documentation to process a claim, the provider shall submit the supporting documentation not more than fifteen (15) days after receiving notice that the supporting documentation is required.

(c) A provider may submit a written request for additional time to submit a claim not more than forty-five (45) days after the claim is incurred. If the administrator receives a request under this subsection, the administrator shall provide an additional forty-five (45) day period for the provider to submit the claim.

(d) If a provider submits a claim more than:

(1) forty-five (45) days and less than fifty-five (55) days after the claim is incurred and has not requested additional time under subsection (c), the administrator may deduct one-tenth (1/10) of the total cost of the claim from the payment to the provider for every day that the provider fails to submit the claim after the period specified in subsection (a); or

(2) fifty-five (55) days after the date the claim is incurred, the administrator may refuse to pay the claim.

(e) If a provider submits a claim more than forty-five (45) days after the claim is incurred or after an additional forty-five (45) day period provided under subsection (c):

(1) sections 6 and 7 of this chapter do not apply to the processing of the claim; and

(2) unless a longer period is provided for by contract, the administrator may refuse to process the claim.

SECTION 6. IC 5-10-8.1-5.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 5.8. (a) Except as provided in subsection (b), a provider shall not bill a covered individual for any amount of a claim not paid by an administrator because the administrator is:**

(1) relieved of responsibility for payment; or

(2) permitted to take a deduction from any amount owed;

to the provider under this chapter.

(b) A provider may bill a covered individual for:

(1) a copayment or deductible; or

(2) an amount billed for health care services that are not covered under the health benefit plan.

(c) A provider that violates subsection (a) is subject to sanction by the provider's licensing authority as follows:

(1) The licensing authority shall automatically suspend the provider's license for at least:

(A) two (2) months for the first violation;

(B) six (6) months for the second violation; and

(C) one (1) year for the third violation.

(2) The licensing authority shall automatically revoke the provider's license for at least one (1) calendar year for the fourth or subsequent violation.

SECTION 7. IC 5-10-8.1-5.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 5.9. (a) An administrator may deny a duplicate claim.**

(b) A provider that submits a duplicate claim shall reimburse the administrator the administrator's actual cost of discovering, determining, and denying the duplicate claim.

(c) An administrator may terminate any payment agreement entered into with a provider if the provider establishes a pattern of failure with at least ten (10) documented failures to submit claims as required under this chapter.

(d) An administrator that terminates an agreement with a provider under subsection (c) shall maintain documentation justifying the termination for review by the department of insurance.

SECTION 8. IC 5-10-8.1-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) The administrator shall pay or deny each clean claim in accordance with section 7 of this chapter.

(b) An administrator shall notify a provider of any deficiencies in a submitted claim not more than

~~(1) thirty (30) days for a claim that is filed electronically; or~~

~~(2)~~ forty-five (45) days ~~for a~~ **after the** claim ~~that~~ is ~~filed on paper;~~ **received by the administrator** and describe any remedy, **including supporting documentation,** necessary to establish a clean claim.

(c) Failure of an administrator to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

SECTION 9. IC 5-10-8.1-7 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 7. (a) The administrator shall pay or deny each clean claim ~~as follows:~~

~~(1) If the claim is filed electronically, not more than thirty (30) days after the date the claim is received by the administrator.~~

~~(2) If the claim is filed on paper,~~ not more than forty-five (45) days after the date the claim is received by the administrator.

(b) If:

(1) the administrator fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the administrator subsequently pays the claim;

the administrator shall pay the provider that submitted the claim interest on the health benefit plan allowable amount of the claim paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning

~~(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or~~

~~(B)~~ forty-six (46) days after the date the claim is filed under subsection ~~(a)(2);~~ **(a);** and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), the administrator shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 10. IC 5-10-8.1-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 9. (a) If an administrator has a reasonable basis on which to believe that a claim submitted for payment:**

(1) is false;

(2) falsely represents that a health care service for which the claim is submitted is medically necessary according to professionally accepted standards; or

(3) contains false statements or representations of a material fact;

the claim may remain pending and the administrator is exempt from the requirements of sections 6 and 7 of this chapter for a reasonable period to allow the administrator to investigate the claim.

(b) If, upon completion of an investigation described in subsection (a), the administrator determines that the claim is valid, the administrator shall pay or deny the claim according to the requirements of sections 6 and 7 of this chapter.

SECTION 11. IC 5-10-8.1-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2005]: **Sec. 10. If a provider submits to an administrator a duplicate claim, a claim that the administrator is unable to process, or a paper claim, the administrator may charge the provider an amount not to exceed one hundred dollars ($100). The amount charged may be recovered by a reduction of any amount owed by the administrator to the provider.**

SECTION 12. IC 5-10-8.1-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 11. If an administrator determines that particular supporting documentation is routinely necessary to process a claim for a particular health care service, the administrator shall establish a standard description of the particular supporting documentation and make the standard description available to providers in an electronic format.**

SECTION 13. IC 27-8-5.7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. **(a)** As used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect **or** impropriety, **including a lack of supporting documentation,** or particular circumstance requiring special treatment preventing payment.

(b) The term does not include a:

(1) duplicate claim; or

(2) claim that:

(A) is submitted more than forty (40) days after the date of service; or

(B) does not comply with the electronic transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 14. IC 27-8-5.7-2.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.2. As used in this chapter, "duplicate claim" means a duplicate of an original claim when the duplicate is filed less than thirty (30) days after the filing of the original claim.**

SECTION 15. IC 27-8-5.7-2.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.8. As used in this chapter, "insured" means an individual entitled to coverage under an accident and sickness insurance policy.**

SECTION 16. IC 27-8-5.7-4.3 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 4.3. As used in this chapter, "supporting documentation" includes:**

(1) verification of employer and insured coverage under an accident and sickness insurance policy;

(2) confirmation of premium payment;

(3) medical information concerning the insured and health care services provided;

(4) information concerning:

(A) the responsibility of another third party payor to make payment; or

(B) confirmation of the amount paid by another third party payor; or

(5) information related to a diagnosis, a treatment, or the provider's identification.

SECTION 17. IC 27-8-5.7-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 4.5. (a) An insurer and a provider shall, in connection with all claims, use the medical data code sets adopted by the United States Secretary of Health and Human Services under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).**

(b) An insurer shall comply with the federal regulations promulgated under sections 503 and 505 of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) in paying a claim submitted by a provider for payment under an accident and sickness insurance policy.

(c) An insurer is not required to pay, and this chapter does not apply to, a claim that is not filed in compliance with the requirements for electronic transaction standards and code sets that govern the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 18. IC 27-8-5.7-4.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 4.6. (a) A provider shall submit a claim for payment under an accident and sickness insurance policy to the insurer:**

(1) not more than forty-five (45) days after the date the claim was incurred, or according to the contractual terms agreed to between the insurer and provider; and

(2) according to the requirements for the electronic

transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

(b) If an insurer requires supporting documentation to process a claim, the provider shall submit the supporting documentation not more than fifteen (15) days after receiving notice that the supporting documentation is required.

(c) A provider may submit a written request for additional time to submit a claim not more than forty-five (45) days after the claim is incurred. An insurer that receives a request under this subsection shall provide an additional forty-five (45) day period for the provider to submit the claim.

(d) If a provider submits a claim more than:

(1) forty-five (45) days and less than fifty-five (55) days after the claim is incurred and has not requested additional time under subsection (c), the insurer may deduct one-tenth (1/10) of the total cost of the claim from the payment to the provider for every day that the provider fails to submit the claim after the period specified in subsection (a); or

(2) fifty-five (55) days after the date the claim is incurred, the insurer may refuse to pay the claim.

(e) If a provider submits a claim more than forty-five (45) days after the claim is incurred or after an additional forty-five (45) day period provided under subsection (c):

(1) sections 5 and 6 of this chapter do not apply to the processing of the claim; and

(2) unless a longer period is provided for by contract, the insurer may refuse to process the claim.

SECTION 19. IC 27-8-5.7-4.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 4.7. (a) Except as provided in subsection (b), a provider shall not bill an insured for any amount of a claim not paid by an insurer because the insurer is:**

(1) relieved of responsibility for payment; or

(2) permitted to take a deduction from any amount owed;

to the provider under this chapter.

(b) A provider may bill an insured for:

(1) a copayment or deductible; or

(2) an amount billed for health care services that are not covered under the accident and sickness insurance policy.

(c) A provider that violates subsection (a) is subject to sanction by the provider's licensing authority as follows:

(1) The licensing authority shall automatically suspend the provider's license for at least:

(A) two (2) months for the first violation;

(B) six (6) months for the second violation; and

(C) one (1) year for the third violation.

(2) The licensing authority shall automatically revoke the provider's license for at least one (1) calendar year for the fourth or subsequent violation.

SECTION 20. IC 27-8-5.7-4.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 4.8. (a) An insurer may deny a duplicate claim.**

(b) A provider that submits a duplicate claim shall reimburse the insurer the insurer's actual cost of discovering, determining, and denying the duplicate claim.

(c) An insurer may terminate an agreement entered into with a provider under IC 27-8-11-3 if the provider establishes a pattern of failure with at least ten (10) documented failures to submit claims as required under this chapter.

(d) An insurer that terminates an agreement with a provider under subsection (c) shall maintain documentation justifying the termination for review by the department.

SECTION 21. IC 27-8-5.7-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with section 6 of this chapter.

(b) An insurer shall notify a provider of any deficiencies in a submitted claim not more than

~~(1) thirty (30) days for a claim that is filed electronically; or~~

~~(2)~~ forty-five (45) days ~~for a~~ **after the** claim ~~that~~ is ~~filed on paper;~~ **received by the insurer** and describe any remedy, **including supporting documentation,** necessary to establish a clean claim.

(c) Failure of an insurer to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

SECTION 22. IC 27-8-5.7-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) An insurer shall pay or deny each clean claim ~~as follows:~~

~~(1) If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer.~~

~~(2) If the claim is filed on paper, within~~ **not more than** forty-five (45) days after the date the claim is received by the insurer.

(b) If:

(1) an insurer fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the insurer subsequently pays the claim;

the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning

~~(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or~~

~~(B)~~ forty-six (46) days after the date the claim is filed under subsection ~~(a)(2);~~ **(a);** and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), an insurer shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 23. IC 27-8-5.7-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 8. **(a) The commissioner may require an insurer to submit reports concerning the insurer's compliance with sections 5 and 6 of this chapter. If reports are required, the commissioner shall prescribe the content, format, and frequency of the reports in consultation with insurers. The commissioner may not require reports to be submitted more frequently than quarterly.**

(b) The commissioner may not use findings from a report submitted under subsection (a) as the basis of a finding of a violation of section 5 or 6 of this chapter. The commissioner may use information contained in a report to form the basis for conducting an examination of the insurer. During this examination, the commissioner may examine data collected for the same period as the period covered by the reports, and the commissioner's examination findings may be used as the basis for a finding of a violation of section 5 or 6 of this chapter.

~~(a)~~ **(c)** If, **after completion of an examination under subsection (b),** the commissioner finds that an insurer has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess, **with reasonable written notice to the insurer of the basis of the commissioner's findings, the penalty to be imposed, and the opportunity for a hearing as described in subsection (e),** an aggregate civil penalty against the insurer according to the following schedule:

(1) If the insurer has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received

from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).

(2) If the insurer has paid at least sixty percent (60%) but less than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the insurer has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

~~(b)~~ **(d)** In determining the amount of a civil penalty under this section, the commissioner shall consider whether the:

(1) insurer's failure to achieve the standards established by **sections 5 and 6 of** this chapter is due to circumstances beyond the insurer's control; **and**

(2) insurer has been in the business of processing claims for two (2) years or less.

~~(c)~~ **(e)** An insurer may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the insurer receives notice of the assessment of the fine.

~~(d)~~ **(f)** If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the insurer under IC 27-4-1 for the same activity.

~~(e)~~ **(g)** Civil penalties collected under this section shall be deposited in the state general fund.

SECTION 24. IC 27-8-5.7-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 11. (a) If an insurer has a reasonable basis on which to believe that a claim submitted for payment:**

(1) is false;

(2) falsely represents that a health care service for which the claim is submitted is medically necessary according to professionally accepted standards; or

(3) contains false statements or representations of a material fact;

the claim may remain pending and the insurer is exempt from the requirements of sections 5 and 6 of this chapter for a reasonable

period to allow the insurer to investigate the claim.

(b) If, upon completion of an investigation described in subsection (a), the insurer determines that the claim is valid, the insurer shall pay or deny the claim according to the requirements of sections 5 and 6 of this chapter.

SECTION 25. IC 27-8-5.7-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 12. If a provider submits to an insurer a duplicate claim, a claim that the insurer is unable to process, or a paper claim, the insurer may charge the provider an amount not to exceed one hundred dollars ($100). The amount charged may be recovered by a reduction of any amount owed by the insurer to the provider.**

SECTION 26. IC 27-8-5.7-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 13. If an insurer determines that particular supporting documentation is routinely necessary to process a claim for a particular health care service, the insurer shall establish a standard description of the particular supporting documentation and make the standard description available to providers in an electronic format.**

SECTION 27. IC 27-8-22.1-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5. **(a) This section applies to an insurer to which IC 27-8-5.7-4.5(a) does not apply.**

~~(a)~~ **(b)** Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) an insurer shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the insurer pays claims for services provided under an accident and sickness insurance policy or a worker's compensation policy; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and

Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for services provided under an accident and sickness insurance policy or a worker's compensation policy.

~~(b)~~ **(c)** If a provider provides services that are covered under an accident and sickness insurance policy or a worker's compensation policy:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection ~~(a);~~ **(b);** and

(2) before the insurer begins using the most current version of the diagnostic or procedure code;

the insurer shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

SECTION 28. IC 27-13-36.2-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. **(a)** As used in this chapter, "clean claim" means a claim submitted by a provider for payment for health care services provided to an enrollee that has no defect **or** impropriety, **including a lack of supporting documentation,** or particular circumstance requiring special treatment preventing payment.

(b) The term does not include a:

(1) duplicate claim; or

(2) claim that:

(A) is submitted more than forty (40) days after the date of service; or

(B) does not comply with the electronic transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 29. IC 27-13-36.2-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 1.5. As used in this chapter, "duplicate claim" means a duplicate of an original claim when the duplicate is filed less than thirty (30) days after the filing of the original claim.**

SECTION 30. IC 27-13-36.2-2.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2005]: **Sec. 2.3. As used in this chapter, "supporting documentation" includes:**

(1) verification of employer and enrollee coverage under an individual contract or a group contract;

(2) confirmation of premium payment;

(3) medical information concerning the enrollee and health care services provided;

(4) information concerning:

(A) the responsibility of another third party payor to make payment; or

(B) confirmation of the amount paid by another third party payor; or

(5) information related to a diagnosis, a treatment, or the provider's identification.

SECTION 31. IC 27-13-36.2-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.5 (a) A health maintenance organization and a provider shall, in connection with all claims, use the medical data code sets adopted by the United States Secretary of Health and Human Services under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).**

(b) A health maintenance organization shall comply with the federal regulations promulgated under sections 503 and 505 of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) in paying a claim submitted by a provider for payment under an individual contract or a group contract.

(c) A health maintenance organization is not required to pay, and this chapter does not apply to, a claim that is not filed in compliance with the requirements for electronic transaction standards and code sets that govern the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 32. IC 27-13-36.2-2.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.6. (a) A provider shall submit a claim for payment under an individual contract or a group contract to the health maintenance organization:**

(1) not more than forty-five (45) days after the date the claim was incurred, or according to the contractual terms agreed to between the health maintenance organization and provider; and

(2) according to the requirements for the electronic

transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

(b) If a health maintenance organization requires supporting documentation to process a claim, the provider shall submit the supporting documentation not more than fifteen (15) days after receiving notice that the supporting documentation is required.

(c) A provider may submit a written request for additional time to submit a claim not more than forty-five (45) days after the claim is incurred. A health maintenance organization that receives a request under this subsection shall provide an additional forty-five (45) day period for the provider to submit the claim.

(d) If a provider submits a claim more than:

(1) forty-five (45) days and less than fifty-five (55) days after the claim is incurred and has not requested additional time under subsection (c), the health maintenance organization may deduct one-tenth (1/10) of the total cost of the claim from the payment to the provider for every day that the provider fails to submit the claim after the period specified in subsection (a); or

(2) fifty-five (55) days after the date the claim is incurred, the health maintenance organization may refuse to pay the claim.

(e) If a provider submits a claim more than forty-five days after the claim is incurred or after an additional forty-five (45) day period provided under subsection (c):

(1) sections 3 and 4 of this chapter do not apply to the processing of the claim; and

(2) unless a longer period is provided for by contract, the health maintenance organization may refuse to process the claim.

SECTION 33. IC 27-13-36.2-2.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.7. (a) Except as provided in subsection (b), a provider shall not bill an enrollee for any amount of a claim not paid by a health maintenance organization because the health maintenance organization is:**

(1) relieved of responsibility for payment; or

(2) permitted to take a deduction from any amount owed;

to the provider under this chapter.

(b) A provider may bill an enrollee for:

(1) a copayment or deductible; or

(2) an amount billed for health care services that are not

covered under the individual contract or group contract.

(c) A provider that violates subsection (a) is subject to sanction by the provider's licensing authority as follows:

(1) The licensing authority shall automatically suspend the provider's license for at least:

(A) two (2) months for the first violation;

(B) six (6) months for the second violation; and

(C) one (1) year for the third violation.

(2) The licensing authority shall automatically revoke the provider's license for at least one (1) calendar year for the fourth or subsequent violation.

SECTION 34. IC 27-13-36.2-2.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.8. (a) A health maintenance organization may deny a duplicate claim.**

(b) A provider that submits a duplicate claim shall reimburse the health maintenance organization the health maintenance organization's actual cost of discovering, determining, and denying the duplicate claim.

(c) A health maintenance organization may terminate a participating provider's participating provider agreement if the participating provider establishes a pattern of failure with at least ten (10) documented failures to submit claims as required under this chapter.

(d) A health maintenance organization that terminates an agreement with a participating provider under subsection (c) shall maintain documentation justifying the termination for review by the department.

SECTION 35. IC 27-13-36.2-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 3. (a) A health maintenance organization shall pay or deny each clean claim in accordance with section 4 of this chapter.

(b) A health maintenance organization shall notify a provider of any deficiencies in a submitted claim not more than

~~(1) thirty (30) days for a claim that is filed electronically; or~~

~~(2)~~ forty-five (45) days ~~for~~ **after** a claim ~~that~~ is ~~filed on paper;~~ **received by the health maintenance organization** and describe any remedy, **including supporting documentation,** necessary to establish a clean claim.

(c) Failure of a health maintenance organization to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

SECTION 36. IC 27-13-36.2-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 4. (a) A health maintenance organization shall pay or deny each clean claim ~~as follows:~~

~~(1) If the claim is filed electronically, not more than thirty (30) days after the date the claim is received by the health maintenance organization.~~

~~(2) If the claim is filed on paper,~~ not more than forty-five (45) days after the date the claim is received by the health maintenance organization.

(b) If:

(1) a health maintenance organization fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the health maintenance organization subsequently pays the claim;

the health maintenance organization shall pay the provider that submitted the claim interest on the lesser of the usual, customary, and reasonable charge for the health care services provided to the enrollee or an amount agreed to between the health maintenance organization and the provider paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning

~~(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or~~

~~(B)~~ forty-six (46) days after the date the claim is filed under subsection ~~(a)(2),~~ **(a);** and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), a health maintenance organization shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 37. IC 27-13-36.2-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. **(a) The commissioner may require a health maintenance organization to submit reports concerning the health maintenance organization's compliance with sections 3 and 4 of this chapter. If reports are required, the commissioner shall prescribe the content, format, and frequency of the reports in consultation with health maintenance organizations. The commissioner may not require reports to be submitted more frequently than quarterly.**

(b) The commissioner may not use findings from a report submitted under subsection (a) as the basis of a finding of a violation of section 3 or 4 of this chapter. The commissioner may

use information contained in a report to form the basis for conducting an examination of the health maintenance organization. During this examination, the commissioner may examine data collected for the same period as the period covered by the reports, and the commissioner's examination findings may be used as the basis for a finding of a violation of section 3 or 4 of this chapter.

~~(a)~~ **(c)** If, **after completion of an examination under subsection (b),** the commissioner finds that a health maintenance organization has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess, **with reasonable written notice to the health maintenance organization of the basis of the commissioner's findings, the penalty to be imposed, and the opportunity for a hearing as described in subsection (e),** an aggregate civil penalty against the health maintenance organization according to the following schedule:

(1) If the health maintenance organization has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).

(2) If the health maintenance organization has paid at least sixty percent (60%) but less than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the health maintenance organization has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

~~(b)~~ **(d)** In determining the amount of a civil penalty under this section, the commissioner shall consider whether the:

(1) health maintenance organization's failure to achieve the standards established by **sections 3 and 4 of** this chapter is due to circumstances beyond the health maintenance organization's control; **and**

(2) health maintenance organization has been in the business of processing claims for two (2) years or less.

~~(c)~~ **(e)** A health maintenance organization may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the health

maintenance organization receives notice of the assessment of the fine.

~~(d)~~ **(f)** If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the health maintenance organization under IC 27-4-1 for the same activity.

~~(c)~~ **(g)** Civil penalties collected under this section shall be deposited in the state general fund.

SECTION 38. IC 27-13-36.2-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 9. (a) If a health maintenance organization has a reasonable basis on which to believe that a claim submitted for payment:**

(1) is false;

(2) falsely represents that a health care service for which the claim is submitted is medically necessary according to professionally accepted standards; or

(3) contains false statements or representations of a material fact;

the claim may remain pending and the health maintenance organization is exempt from the requirements of sections 3 and 4 of this chapter for a reasonable period to allow the health maintenance organization to investigate the claim.

(b) If, upon completion of an investigation described in subsection (a), the health maintenance organization determines that the claim is valid, the health maintenance organization shall pay or deny the claim according to the requirements of sections 3 and 4 of this chapter.

SECTION 39. IC 27-13-36.2-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 10. If a provider submits to a health maintenance organization a duplicate claim, a claim that the health maintenance organization is unable to process, or a paper claim, the health maintenance organization may charge the provider an amount not to exceed one hundred dollars ($100). The amount charged may be recovered by a reduction of any amount owed by the health maintenance organization to the provider.**

SECTION 40. IC 27-13-36.2-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 11. If a health maintenance organization determines that particular supporting documentation is routinely necessary to process a claim for a particular health care service, the health maintenance organization shall establish a standard description of the particular supporting documentation**

and make the standard description available to providers in an electronic format.

SECTION 41. IC 27-13-41 IS REPEALED [EFFECTIVE JULY 1, 2005].

SECTION 42. [EFFECTIVE JULY 1, 2005] **(a) IC 5-10-8.1, IC 27-8-5.7, and 27-13-36.2, all as amended by this act, apply to claims incurred after June 30, 2005.**

(b) This SECTION expires July 1, 2007.